

## **Statement for the Record**

### **American College of Physicians**

#### **Hearing before the House Energy & Commerce Health Subcommittee**

#### **“Making Health Care Work for American Families: Improving Access to Care”**

**March 24, 2009**

Thank you, Chairman Pallone and Ranking Member Deal, for allowing me to share the American College of Physicians (ACP's) views on the primary care workforce and how it affects access to care.

I am Jeffrey P. Harris, MD, FACP, the President of the American College of Physicians, a general internist for three decades, who worked as a Clinical Associate Professor of Medicine at the University of Virginia School of Medicine. Until very recently, I practiced in a small, rural town in Virginia with a population of 40,000 people. I am pleased to be able to represent the College today at this hearing.

The American College of Physicians represents 126,000 internal medicine physicians and medical students. ACP is also the nation's largest medical specialty society and its second largest physician membership organization.

We are experiencing a primary care shortage in this country, the likes of which we have not seen. The expected demand for primary care in the United States continues to grow exponentially while the nation's supply of primary care physicians dwindles and interest by U.S. medical graduates in primary care specialties steadily declines. The reasons behind this decline in primary care physician supply are multi-faceted and complex. Key factors include the rapid rise in medical education debt, decreased income potential for primary care physicians, failed payment policies, and increased burdens associated with the practice of primary care.

A strong primary care infrastructure is an essential part of any high-functioning healthcare system. In this country, primary care physicians provide 52 percent of all ambulatory care visits, 80 percent of patient visits for hypertension, and 69 percent of visits for both chronic obstructive pulmonary disease and diabetes, yet they comprise only one-third of the U.S. physician workforce.<sup>1 2</sup> Those numbers are compelling, considering the fact that primary care is known to improve health outcomes, increase quality, and reduce healthcare costs.

The hallmarks of primary care medicine include: first contact care, continuity of care, comprehensive care and coordinated care. The two specialties that provide the majority of adult primary care in the U. S. are family medicine and internal medicine. The training and care that family physicians and general internists provide are distinctly

different. Family physicians are trained to diagnose and treat a wide variety of ailments in patients from children to old age. Family physicians receive a broad range of training that includes internal medicine, pediatrics, obstetrics and gynecology, psychiatry, and geriatrics.<sup>3</sup> General internists, on the other hand, provide long-term, comprehensive care in the office and the hospital, managing both common and complex illness of adolescents, adults, and the elderly. Internists receive in-depth training in the diagnosis and treatment of conditions affecting all organ systems. As documented below, the declining supply of general internal medicine physicians is of particular importance to Medicare beneficiaries' access to care. In 2007, internists provided 229,131,238 allowed services to Medicare patients compared to 130,120,289 for family physicians and 17,780,062 for general practitioners." (Source: CMS).

### **Primary Care Workforce: The Problem**

#### *The U.S. is Facing an Escalating Shortage of Primary Care Physicians*

There are many regions of the country that are currently experiencing shortages in primary care physicians. The Institute of Medicine (IOM) reports that it would take 16,261 additional primary care physicians to meet the need in currently underserved areas alone.

Demand for primary care physicians outpaces supply faster than any other specialty group. Specifically, the AAMC estimates that primary care accounts for 37 percent of the total projected shortage in 2025 – about 46,000 FTE primary care physicians.<sup>4</sup> These findings are consistent with recently published projections by researchers from the University of Missouri and the Health Resources Services Administration. The study also predicted that population growth and aging will increase family physicians' and general internists' workloads by 29 percent between 2005 and 2025.<sup>5</sup> Further, greater use of nurse practitioners (NPs) and physician assistants (PAs) are not expected to make enough of an impact on this shortfall.<sup>6</sup> Annual numbers of NP graduates fell from 8,200 in 1998 to 6,000 in 2005 and are projected to fall to 4,000 by 2015. In addition, only about 65 percent of NPs currently work in primary care settings. The number of PA graduates have remained stable at about 4,200 per year, but it is important to note that only one-third of PAs practice in primary care settings.<sup>7</sup>

ACP is particularly concerned about the adequacy of the supply of general internists who provide care in outpatient settings.

- General internists are leaving practice sooner than other physician specialties at the same time that fewer medical students and residents are choosing to make the practice of general internal medicine and primary care their central career goal. Approximately 21 percent of physicians who were board certified in the early 1990s have left internal medicine, compared to a 5 percent departure rate for internal medicine subspecialists.<sup>8</sup>

Equally alarming is the fact that the pipeline of incoming primary care physicians is also drying up, as medical students are drawn to more highly compensated specialties.

- In a survey of fourth-year medical students at eleven U.S. medical schools in the spring of 2007, 23.2 percent reported they were most likely to enter careers in internal medicine, including only 2.0 percent who reported that they were likely to enter careers in general internal medicine.<sup>9</sup> If this trend continues, a shortage of primary care physicians will likely develop more rapidly than many now anticipate.
- The number of third-year internal medicine residents choosing to pursue a career in an internal medicine subspecialty or other specialties has risen each year for the past eight years, while the percentage choosing careers in general internal medicine has steadily declined. In 2007, only 23 percent of third-year internal medicine residents intended to pursue careers in general internal medicine, down from 54 percent in 1998.<sup>10</sup>
- For each of the past two years, the number of U.S. medical students choosing internal medicine residencies has decreased by approximately 1 percent from the previous year. According to the 2009 National Resident Matching Program report, 2,632 U.S. seniors at medical schools enrolled in an internal medicine residency program -- down from 2,660 in 2008 and 2,680 in 2007. These numbers are particularly striking when compared with 3,884 U.S. medical school graduates who chose internal medicine residency programs in 1985,"said Steven E. Weinberger, MD, FACP, senior vice president for medical education and publishing, American College of Physicians (ACP), in response to the match results for 2009. "We are witnessing a generational shift from medical careers that specialize in preventive care, diagnostic evaluation, and long-term treatment of complex and chronic diseases, to specialties and subspecialties that provide specific procedures or a very limited focus of care."
- The 2009 match numbers include students who will ultimately specialize in general internal medicine and provide primary care, as well as those who will enter a subspecialty of internal medicine, such as cardiology or oncology. Currently, approximately 20 to 25 percent of internal medicine residents eventually choose to specialize in general internal medicine, compared with 54 percent in 1998. "This transition is happening at a time when America's aging population is increasing, and the demand for general internists and other primary care physicians will continue to grow at a much faster rate than the primary care physician supply," noted Dr. Weinberger.

*Without more Primary Care Physicians, Expanded Health Insurance Coverage Will Not Ensure Access to Care*

ACP strongly supports the need to provide all Americans with access to affordable health insurance coverage. We are committed to working with Congress and President Obama

to enact bipartisan legislation this year to achieve this goal, and would be please to share with the subcommittee ACP's specific recommendations on coverage.

We also know that health reforms to expand coverage will *fail* to improve outcomes and lower costs unless programs are created to reverse a growing shortage of primary care physicians:

- Persons who do not have access to health insurance coverage are less likely to have a physician as a regular source of care.<sup>11</sup> They are also less likely to comply with recommended treatments, to take their medications, and receive recommended preventive services. Accordingly, as more persons obtain health insurance coverage as a result of health care reform, they will appropriately seek to form a relationship with an internist, family physician, or pediatrician to serve as their regular source of care.
- Increases in the numbers of patients with chronic illnesses will accelerate the demand for primary care. According to *Health Affairs*, "In 2005, 133 million Americans were living with at least one chronic condition. In 2020, this number is expected to grow to 157 million ... Currently, most chronic illnesses care takes place in primary care physician practices ... Compared with specialist-only care, primary care offers high quality care at lower cost for patients with chronic conditions." The authors support the development of multidisciplinary teams in primary care and public health and recommend that the U.S. adopt the goal of "half of U.S. clinicians practice in primary care."<sup>12</sup>
- Most established primary care physicians are currently working at full capacity and will be unable to absorb the increased number of patient visits that will accompany coverage expansions. A rapid expansion of primary care capacity will accordingly be needed.

**Patients will experience reduced access to care if health care reform does not expand the primary care physician workforce capacity at the same time as coverage is expanded:**

- For the newly insured, there will be long wait times to get an appointment with a primary care physician, if they are able to find one at all.
- In a growing number of communities, it may become impossible for people who do not currently have a relationship with a primary care physician to find an internist, family physician or pediatrician who is taking new patients. Not because established primary care physicians do not want to accept the newly-insured into their practices, but because they have no time left in an already over-scheduled day to take on any additional patients.
- Patients of established primary care physicians who already are working at full capacity, but who still try to accept more of the newly insured into their practices,

will experience a reduction in the qualitative time their doctor is able to spend with them. Wait times for appointments will increase. Despite insurance coverage, without changes in the way care is provided, physicians may have to further decrease the time they currently spend with patients in order to try to accommodate increased demand for services – which could have a negative impact on quality, access, and timeliness. Primary care physician “burn out” is likely to increase because of physician dissatisfaction with not being able to spend enough time with their patients or being able to see them in a timely manner. Such burn outs will likely lead more primary care physicians to consider getting out of practice, which will then put further stress on remaining primary care physicians in their community.

- Massachusetts’ experience is a case in point of what can happen if coverage is expanded without expanding the primary care workforce. When health insurance coverage was recently expanded to nearly 95 percent of the state’s residents, some low income residents reported difficulty finding a physician or getting an appointment.<sup>13</sup> In fact, the wait to see primary care physicians in Massachusetts has reportedly grown to as long as 100 days.<sup>14</sup>
- The higher price tag associated with coverage expansions that do not concurrently address the need to rapidly expand primary care physician workforce will be borne by taxpayers and employers in the form of higher taxes and by increases in premiums and cost-sharing for persons who have health insurance coverage.

### **Primary Care is the Best Medicine for Better Care and Lower Cost**

A fundamental goal of delivery system reform should be to recognize and support the value of primary care in improving outcomes; reducing preventable over-utilization of emergency rooms, hospitals and testing facilities; and achieving overall costs savings.

More than 100 studies, referenced in ACP’s recent paper, *How is a Shortage of Primary Care Physicians Affecting the Quality and Cost of Medical Care?*, demonstrate that primary care is consistently associated with better outcomes and lower costs of care. Highlights of that paper include:

- When compared with other developed countries, the United States ranked lowest in its primary care functions and lowest in health care outcomes, yet highest in health care spending.<sup>15 16 17</sup>
- Primary care has the potential to reduce costs while still maintaining quality.<sup>18 19 20 21 22</sup>
- States with higher ratios of primary care physicians to population have better health outcomes, including mortality from cancer, heart disease or stroke.<sup>23 24</sup>

- Individuals living in states with a higher ratio of primary care physicians to population are more likely to report good health than those living in states with a lower such ratio.<sup>25</sup>
- The supply of primary care physicians is also associated with an increase in life span.<sup>26 27</sup> An increase of just one primary care physician is associated with 1.44 fewer deaths per 10,000 persons.<sup>28</sup>
- Primary care physicians have also been shown to provide better preventive care compared to specialists, reflecting their ability to better manage the whole health of patients.<sup>29 30 31</sup>
- The preventive care that primary care physicians provide can help to reduce hospitalization rates.<sup>32 33 34 35 36</sup> During the year 2000, an estimated 5 million admissions to U.S. hospitals involved hospitalizations that may have been preventable with high quality primary and preventive care treatment; the resulting cost was more than \$26.5 billion. Assuming an average cost of \$5,300 per hospital admission, a 5 percent decrease in the rate of potentially avoidable hospitalizations alone could reduce inpatient costs by more than \$1.3 billion.<sup>37</sup>
- Hospital admission rates for five of 16 ambulatory care-sensitive conditions "for which good outpatient care can potentially prevent the need for hospitalization, or for which early intervention can prevent complications or more severe disease," increased between 1994 and 2003, suggesting worsening in ambulatory care access or quality for those conditions.<sup>38 39</sup> Studies of certain ambulatory care-sensitive conditions have shown that hospitalization rates and expenditures are higher in areas with fewer primary care physicians and limited access to primary care.<sup>40</sup>
- One study found that an increase of 1 primary care physician per 10,000 population in a state was associated with a rise in that state's quality rank *and a reduction in overall spending by \$684 per Medicare beneficiary.*<sup>41</sup> By comparison, an increase of 1 specialist per 10,000 people was estimated to result in a drop in overall quality rank of nearly 9 places and increase overall spending by \$526 per Medicare beneficiary.

## **Solutions to Improving the Primary Care Workforce**

**1. ESTABLISH A NATIONAL HEALTH CARE WORKFORCE POLICY:** The federal government should develop a national health care workforce policy that includes sufficient support to educate and train a supply of health professionals that meets the nation's health care needs and specifically to ensure an adequate supply and spectrum of primary care physicians trained to manage care for the whole patient. General internists, who provide long-term, comprehensive care in the office and the hospital, managing both common and complex illness of adolescents, adults, and the elderly, should be a crucial component of a high functioning primary care system.

***Rationale:***

In the U.S., the numbers and types of health care professionals being trained are largely determined by the availability of training programs, the number of applicants, and inpatient service needs of academic medical centers. But, institutional service needs are a poor indicator of national health workforce requirements, particularly as patient care has continued to shift from inpatient to outpatient settings. The nation needs sound research methodologies embedded in its workforce policy to determine the nation's current and future needs for appropriate numbers of physicians by specialty and geographic areas. The Council on Graduate Medical Education has made numerous calls on the federal government to establish of a national health care workforce policy, most recently in September 2007. In its December 2008 report, the Institute of Medicine did so as well, recommending that the Department of Health and Human Services, along with other public and private partners, "develop a comprehensive national strategy to assess and address current and projected gaps in the number, professional mix, geographical distribution, and diversity" of the health care workforce.

In June 2006, the AAMC recommended a 30 percent increase in U.S. medical school enrollment and an expansion of Graduate Medical Education (GME) positions to accommodate this growth.<sup>42</sup> The current Medicare GME-funding limits on residency training positions are impeding the establishment of new residency programs and additional training positions in existing programs. While medical schools have done their part to expand class sizes, this effort will not increase the total number of physicians in the country unless GME capacity is increased as well. ACP has considered the option of increasing the number of overall GME positions to increase the supply of physicians, but concluded that increasing the overall pool of physicians would not assure that adequate numbers enter and remain in practice in primary care. Instead, ACP recommends a more targeted approach, recognizing the nation's increasing demographic demands for health care and the dwindling supply of primary care physicians. ACP recommends strategically increasing the number of Medicare-funded GME positions in adult primary care specialties. For internal medicine, the College recommends that the positions be increased in IM- primary care positions rather than IM categorical positions.

With an estimated shortage of 44,000 – 46,000 primary care physicians anticipated by 2025, the federal government must act now to eliminate such a deficit. Since it takes 7 years to educate and train a primary care physician, this expansion of GME positions must start now to avert the predicted shortfall.

***2. INVEST IN THE PRIMARY CARE PIPELINE***

**Incentives for Medical Students:** The federal government should create incentives for medical students to pursue careers in primary care and practice in areas of the nation with greatest need by developing or expanding programs that eliminate student debt for physicians choosing primary care linked to a reasonable service obligation in the field and creating incentives for these physicians to remain in underserved areas after completing their service obligation. This should include:

- a. New loan repayment and medical school scholarship programs in exchange for primary care service in critical shortage health facilities and geographic areas.
- b. Increase funding for scholarships and loan repayment programs under Title VII.
- c. Increase funding for National Health Service Corps (NHSC) scholarships and loan repayment programs.

***Rationale:***

**New loan repayment and scholarship programs:** There are many health care facilities across the country facing shortages of primary care physicians. A Critical Shortage Health Facility is defined as a public or private nonprofit health facility that does not serve a health professional shortage area (HPSA), but has a critical shortage of primary care physicians. ACP proposes the establishment of scholarships (not to exceed \$30,000 per year to a maximum of four years) in family practice, internal medicine and pediatrics through the Department of Health & Humans Services (HHS) that require graduates to practice in critical shortage health facilities for a minimum of two years and up to four years for each year that such scholarship is awarded.

The College also calls for the establishment of a loan repayment program to primary care physicians in the fields of family practice, internal medicine and pediatrics who agree to practice in an area of the country that is not a health professional shortage area (as designated under section 332), but has a critical shortage of primary care physicians (as determined by the Secretary) in such fields. A maximum of \$35,000 per year in loan repayment (principal and interest) should be provided for each year of such service obligation.

These programs would require service in specific health facilities that are experiencing critical shortages of primary care physicians, or in a physician office or other facility in a geographic area of the country that is experiencing a critical primary care shortage. They offer an alternative option to service in HPSAs through National Health Service Corps (NHSC) and would offer a broader impact on increasing the primary care workforces as they would be limited to primary care physicians and would allow them to meet their service obligation in more areas of the country and in more facilities that are experiencing a critical primary care shortage. Since the NHSC requires that physicians practice in designated HPSAs, it excludes many areas of the country and facilities that are experiencing critical shortages.

**Increase funding for Title VII:** The Primary Care Loan (PCL) program awards funds to accredited schools for medical students who agree to enter and complete residency training in primary care within four years after graduation and practice in primary care for the life of the loan. Such loans can serve as a great incentive for medical students considering careers in primary care.



The Faculty Loan Repayment Program is designed to assist degree-trained health professionals from disadvantaged backgrounds in pursuing academic careers. Individuals selected agree to serve on the faculty of an accredited health professions college or university for a minimum of two years for payment of up to \$20,000 of their educational loans. In FY 2004, this program received 148 applications, but only 43 were funded.

The Scholarships for Disadvantaged Students Programs provides scholarships to full-time, financially needy students from disadvantaged backgrounds, enrolled in health professions and nursing programs. In FY2008, the Scholarships for Disadvantaged Students program distributed \$42.3 million in scholarship funds to 224 colleges and universities, ranging from \$1,548 to \$1,781,268; the average award was \$189,121. Such scholarships help greatly in diversifying the health care workforce.

**Increase funding for the National Health Service Corps:** The NHSC scholarship and loan repayment programs provide payment toward tuition/fees or student loans in exchange for service in an underserved area. The programs are available for primary medical, oral, dental, and mental and behavioral professionals. Participation in the NHSC for 4 years or more greatly increases the likelihood that a physician will continue to work in an underserved area after leaving the program. Over the years, the number of clinicians in those programs has grown from 180 to over 4,000. In 2000, the NHSC conducted a large study of NHSC clinicians who had completed their service obligation up to 15 years before and found that 52 percent of those clinicians continued to serve the underserved in their practice.<sup>43</sup> The programs under NHSC have proven to make an impact in meeting the health care needs of the underserved, and with more appropriations, they can do more.

The NHSC estimates that nearly 50 million Americans currently live in health professions shortage areas (HPSAs) - underserved communities which lack adequate access to primary care services - and that 27,000 primary care professionals are needed to adequately serve the people living in HPSAs. Currently, over 4,000 NHSC clinicians are caring for nearly 4 million people.<sup>44</sup> The outstanding need remains unmet.

Limited funding has reduced new NHSC awards from 1,570 in FY 2003 to an estimated 947 in FY 2008, a nearly 40 percent decrease. The NHSC scholarship program already receives seven to fifteen applicants for every award available. The National Advisory Council on the National Health Service Corps has recommended that Congress double the appropriations for the NHSC to more than double its field strength to 10,000 primary care clinicians in underserved areas.<sup>45</sup>

**Deferment of Medical School Loans:** Congress should enact legislation to allow deferment of educational loans throughout the duration of training in primary care residency programs.

***Rationale:***

During residency training, physicians receive a stipend in acknowledgment of the patient care services they provide. However, medical residents receive far less income and

typically work many more hours per week (up to 80 hours) than their counterparts with postgraduate degrees in other professions. Loan repayment in residency makes it even more difficult for physicians-in-training to start or support a family and leaves little discretionary income for products that will advance physicians' professional development (conferences, journal subscriptions, etc.). By deferring payment of interest and principal on medical student loans until after completion of postgraduate training, residents will have increased funds necessary for professional development and more of an opportunity for a reasonable lifestyle. This will reduce financial pressure for residents to moonlight to supplement their income. It will also better enable young physicians who want to enter primary care careers to do so with less pressure to enter a more lucrative specialty in order to pay off their student debts.

### **3. REFORM PAYMENTS TO SUPPORT PRIMARY CARE**

#### **Make Payment to Primary Care Physicians Competitive with Other Specialty and Career Choices:**

Congress should enact Medicare payment reform so that the career choices of medical students and young physicians are largely unaffected by considerations of differences in earnings expectations. This will require immediate increases in Medicare fee-for-service payments to primary care physicians, starting in the current calendar year, followed by continued annual increases in payments for primary care physicians.

#### ***Rationale:***

Medical students and young physicians should make career decisions based on their interests and skills, instead of being influenced to a great extent by differences in earnings expectations associated with each specialty. Yet there is extensive evidence that choice of specialty is greatly influenced by the under-valuation of primary care by Medicare and other payers compared to other specialties.

- A 2007 survey of the perception of fourth-year medical students pertaining to internal medicine, compared to other specialties they had chosen or considered, is telling. Respondents perceived internal medicine as having lower income potential while requiring more paperwork and a greater breadth of knowledge.<sup>46</sup>
- A recent study compared residency position fill-rates with average starting salaries by specialty and found that U.S. medical students tend to choose more highly compensated specialties. For example, the average starting salary for family medicine was \$130,000 while the highest average starting salaries were in radiology and orthopedic surgery. In 2007, only 42.1 percent of first-year family medicine residency positions were filled by U.S. medical school graduates compared to 88.7 percent in radiology and 93.8 percent in orthopedic surgery.<sup>47</sup>
- A 2008 analysis found a strong direct correlation between higher overall salary and higher fill rates with U.S. graduates.<sup>48</sup>

Currently, the average primary care physician earns approximately 55 percent of the average earnings for all other non-primary care physician specialties.<sup>49</sup> This

compensation gap is contributing to a growing shortage of primary care physicians, and particularly primary care physicians in smaller practices.

To eliminate differential income as a critical factor in medical student/resident choice of specialty, the average net income for primary care physicians would need to be raised to be competitive with the average net income for all other specialties.

- The level of payment for services provided principally by primary care physicians must be increased to be competitive with other specialty and practice choices, taking into account any additional years of training associated with specialty training programs.
- A target goal for raising primary care reimbursement to make it competitive with other specialty and practice options should be established by the federal government based on, in part, an analysis of the current marketplace and the price sensitivity of physicians with respect to projected income and choice of specialty.

For instance, Medicare and all other payers would need to increase their payments to primary care physicians by 7.5-8 percent per year over a five-year period, above the baseline for all other specialties, to bring the average of the median earnings for primary care physicians to 80 percent of those for all other specialties, all other factors being equal. Achieving 100 percent parity would require annual increases of 12-13 percent over five years.

Such market competitiveness targets could also be adjusted to take into account expansion of existing programs and development of new ones to reduce or eliminate student debt for physicians selecting primary care careers, so that the combined differential between debt and expected earnings is comparable to other specialty choices.

The Medicare Payment Advisory Commission (MedPAC) recommends that Medicare pay a bonus for primary care services furnished by physicians whose practices focus on primary care. While MedPAC would defer to Congress to determine the precise bonus payment amount, it identifies the 10 percent bonus currently paid for services furnished in health professional shortage areas and the 5 percent bonus that was previously provided for services in areas with a low physician-to-population ratio as a starting point for discussion. MedPAC initially made this recommendation in June 2008—when it devoted an entire chapter in its Report to Congress to “Promoting the Use of Primary Care”—and reiterated it in its March 2009 Report to Congress “to emphasize its importance.” The MedPAC rationale for the bonus payment is that primary care services are undervalued and that physicians focused on furnishing primary care services cannot increase the frequency with which they furnish these services—as can be more readily done for tests and procedures—to increase their revenue.

ACP appreciates the MedPAC attention to the payment disparity problem. The MedPAC recommendation that the bonus payment not increase the overall amount that Medicare spends on physician services, however, deviates from the College’s position that the

funding should not be restricted to budget neutral adjustments in the Medicare physician fee schedule and instead should take into consideration the impact of primary care in reducing overall Medicare costs, including costs under Part A associated with reductions in preventable hospital, emergency room and intensive care unit visits associated with primary care.

A better way to fund primary care would be to re-define budget-neutrality rules to consider the impact of paying more for primary care on total aggregate Medicare spending, Parts A, B, C and D combined. A portion of anticipated savings in other parts of Medicare (such as from fewer preventable hospital or emergency room admissions associated with care coordination by primary care physicians) could then be applied to fund increased payments for primary care.

It also is not clear whether MedPAC intends for the adjustment to be a one-time adjustment or one that is sustained and continued over several years until the market compensation gap between primary care and other specialties is closed. The College believes that a one-time adjustment, even if it is as high as 10 percent, will be insufficient to make primary care competitive with other specialties. In addition, the amount of the adjustment should not be left up to Congress to decide each year, but should instead be scheduled in advance so that annual compensation increases in increments until parity reached with other specialties. Such predictability is needed to influence the career decisions of medical students and associates who are contemplating the current and future potential of primary care compensation, as well as to established primary care physicians who may be contemplating a career change or early retirement.

**Support New Primary Care Delivery Models/Patient Centered Medical Home:**

Public and private payers should invest in other new practice models that support the ability of primary care physicians to deliver comprehensive, preventive, and coordinated care to patients. ACP strongly supports the patient centered primary care model of health care delivery and recommends that the current Medicare demonstration be expanded to a pilot project.

***Rationale:***

The Patient-Centered Medical Home is a team-based model of care led by a personal physician who provides continuous and coordinated care throughout a patient's lifetime to maximize health outcomes. The PCMH practice is responsible for providing for all of a patient's health care needs or appropriately arranging care with other qualified professionals. This includes the provision of preventive services, treatment of acute and chronic illness, and assistance with end-of-life issues.

The PCMH enjoys the support of a wide range of health care stakeholders, including physician organizations, consumer organizations, employers, health plans, and quality-focused organizations. Policymakers view it as a promising reform model, with Congress authorizing the Medicare Medical Home demonstration project through a 2006 law and supplementing it with dedicated funding and increased ability for expansion through a 2008 law. MedPAC recommends a Medicare medical home pilot project to supplement

the demonstration currently being developed that focuses on practices that use advanced HIT. Other bills have been or are likely to be introduced that would direct additional Medicare medical home test projects.

Numerous states are incorporating PCMH tests into reform of their Medicaid and SCHIP programs. There are a myriad of private payer PCMH tests, many involving multiple health plans, underway or being developed across the country.

Practices must demonstrate that they have the structure and capability to provide patient-centered care to be recognized as a PCMH. The most recently used PCMH recognition module classifies a qualifying practice as one of three medical home levels, each indicating a progressive level of capability. While practices must demonstrate capability beyond what is typical, they have some ability to reach the requisite PCMH recognition score in different ways. ACP is aware that government programs exist that address focused areas that are relevant to the PCMH. The current scope of work governing the Medicare Quality Improvement Organization (QIO) program involves 14 organizations focusing on improving transitions in care, e.g. inpatient to ambulatory setting, in certain geographic areas.<sup>50</sup> The Department of Health and Human Services maintains a program that facilitates the ability of physicians to provide language translation services to patients. The federal government should provide sufficient funding for programs to help smaller physician practices qualify as PCMHs.

In addition, the current Medicare Medical Home Demonstration, which is limited to eight states, should be expanded to a national pilot. CMS should also set a timeline for expeditiously transitioning to a new payment model for all practices nationwide that have voluntarily sought and received recognition as Patient-Centered Medical Homes following completion of the Medicare demonstration/pilot. The budget should also provide states with dedicated federal funding to implement PCMH demos for Medicaid, SCHIP, and all-payer programs.

The Commonwealth Fund's Commission on a High Performing Health Care System recently issued a report that advocates that the federal government "Strengthen and reinforce patient-centered primary care through enhanced payment of primary care services and changing the way we pay for primary care to encourage the adoption of the medical home model to ensure better access, coordination, chronic care management, and disease prevention." The report estimates that widespread implementation of the medical home model would reduce national health care expenditures by \$175 billion over ten years.<sup>51</sup>

**Eliminate Payment Cuts under the Sustainable Growth Rate (SGR):** Congress should eliminate payment cuts, as a result of the flawed SGR, and account for the true costs associated with providing updates. Updates should reflect increases in the costs of medical practice by increasing Medicare baseline spending assumptions.

***Rationale:***

Over the past several years, one of the College's main priorities has been urging Congress to reform Medicare's flawed physician payment formula known as the Sustainable Growth Rate, or SGR. This formula has led to scheduled annual cuts in physician payments for the past seven consecutive years. On January 1, 2010 physicians face a 21 percent Medicare payment decrease unless Congress intervenes to avert this cut. This uncertainty in Medicare reimbursement rates makes it nearly impossible for physicians to plan their budgets for their practices. Although Congress has acted to avert scheduled Medicare payment cuts in the last several years, it has not acted to permanently fix the flawed payment formula. Unless Congress acts to provide the funding necessary to fix this flawed Medicare payment formula, physicians will face continued uncertainty over Medicare reimbursement rates in the future.

The College appreciates that the President's budget recognizes a shortfall in the current Medicare payment formula and intends to dedicate funding to account for "additional expected Medicare payments to physicians over the next 10 years." Accounting for funds needed to reform the flawed sustainable growth rate (SGR) payment formula could remove the greatest single barrier to reaching a consensus on a long-term solution to the SGR payment cuts.

**Summary and Conclusions**

ACP applauds Congress and the Administration for their resolve in addressing major health care reform this year. The College firmly believes that sustaining and improving the primary care workforce is essential to providing patients with access to high-quality care at reduced costs. Congress should take the necessary steps to ensure an adequate primary care workforce by:

- Recognizing that primary care is positively and consistently associated with improved outcomes, reduced mortality, lower utilization of healthcare resources, and lower overall costs of care.
- Developing a national workforce policy to help ensure adequate numbers, availability and distribution of primary care physicians
- Investing in the pipeline of incoming primary care physicians by creating new loan repayment and medical school scholarship programs, increasing funding for Title VII programs, increasing funding for the National Health Service Corps, and allowing deferment of educational loans throughout training in primary care residency programs
- Increasing Medicare payments to primary care physicians to make them competitive with other specialties and career choices
- Modifying Medicare budget neutrality rules to allocate a portion of anticipated savings associated with primary care, such as from reduced preventable hospital and emergency room admissions, to fund increases in payments for primary care services
- Funding programs to support and expand the Patient-Centered Medical Home

- Eliminating payment cuts from the SGR and accounting for the true costs associated with providing updates that reflect increases in the costs of medical practice by increasing Medicare baseline spending assumptions

The College appreciates the opportunity to share its views on the primary care workforce. We look forward to working with this committee on reforms that will expand health insurance coverage to all Americans, improve the quality of care, reduce costs, and ensure that all patients have access to a primary care physician.

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